OHS/LSW-400 (9/03)

Michigan Department of Consumer & Industry Services
Board of Social Workers
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

APPLICATION FOR RE-REGISTRATION

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, a license will not be issued.

Type or Print Only

Board Use Only
License Number
Date of Licensure

I AM APPLYING FOR RE-REGISTRATION OF THE FOLLOWING (Check One Only):

- ☐ **Certified Social Worker - Fee: $60.00 71-6801-06**
- ☐ **Social Worker - Fee: $60.00 71-6801-06**
- ☐ **Social Work Technician - Fee: $60.00 71-6801-06**

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name

U.S. Social Security Number	Date of Birth	Michigan Registration Number and Expiration Date

Street Address

City	State	ZIP Code

Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony?	☐ Yes	☐ No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	☐ Yes	☐ No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	☐ Yes	☐ No
4. Have you been treated for substance abuse in the past 2 years?	☐ Yes	☐ No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	☐ Yes	☐ No
6. Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?	☐ Yes	☐ No

The Department of Consumer & Industry Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

7. Have you ever had a federal or state health professional registration or license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you? ☐ Yes ☐ No

8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? ☐ Yes ☐ No

9. Has your Michigan social work registration been lapsed for more than three years? ☐ Yes ☐ No
If yes, list each state, the license number, the date issued, and how the license was obtained (either endorsement or examination). DO NOT LIST TEMPORARY LICENSES. **You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.)**

State	Permanent License/Registration Number	Date of Issue	How obtained (Endorsement/Examination)

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of their pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date

OHS/HLD-001 (9/03)

Michigan Department of Consumer & Industry Services
Bureau of Health Services
P.O. Box 30670
Lansing, MI 48909

VERIFICATION OF LICENSURE OR REGISTRATION

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, a license will not be issued.

PART 1: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion:

Check the profession for which you are requesting verification.

- ☐ Chiropractic
- ☐ Counseling
- ☐ Dentistry
- ☐ Marriage & Family Therapy
- ☐ Medicine
- ☐ Nursing
- ☐ Nursing Home Adm.
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Osteopathy
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Physician's Assistants
- ☐ Podiatry
- ☐ Psychology
- ☐ Sanitarians
- ☐ Social Work
- ☐ Veterinary

First Name	Middle Name	Last Name
Previous Names Used	**Date of Birth**	**U. S. Social Security Number**
State Board	**License Number**	**Date of Issue**

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Basis for Issuance of License:		Type of License:
☐ Examination - Please indicate type of exam (National, Regional, State, etc.) ☐ Endorsement - Please indicate name of state		
License Status ☐ Current ☐ Lapsed ☐ Inactive	**Original Issue Date**	**Expiration Date**

Has the applicant incurred any formal or informal actions in your State?

☐ No ☐ Yes - If Yes, Please attach certified copies of any actions.

Are formal or informal actions pending?

☐ No ☐ Yes

Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?

☐ No ☐ Yes

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

Signature _____ **Date** _____

Type or Print Name _____

(S E A L)

Title _____

Full Name of Licensing Board _____